

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: 11-W-00125/5

TITLE: Wisconsin Medicaid Section 1115 Health Care Reform Demonstration
(BadgerCare)

AWARDEE: State of Wisconsin Department of Health and Family Services

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I. PREFACE

The following are Special Terms and Conditions (STCs) for the award of the Wisconsin State Medicaid Section 1115 Health Care Reform Demonstration renewal submitted on December 23, 2003. The STCs have been arranged into three broad subject areas: General Conditions for Approval, Legislation, and Program Design/Operational Plan.

In addition, specific requirements are attached and entitled: General Financial Requirements (Attachment A); General Program Requirements (Attachment B); General Reporting Requirements (Attachment C); Monitoring Budget Neutrality (Attachment D); Operational Protocol (Attachment E), and CMS Encounter Data Set (Attachment G).

The State agrees that it will comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to: the Americans with Disabilities Act; Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; and the Age Discrimination Act of 1975. As part of the review of the operational protocol that the State is required to submit, CMS will examine the State's proposed operational procedures to ensure their consistency with the requirements set forth in the above Federal statutes.

Letters, documents, reports, or other material that is submitted for review or approval shall be sent to the Wisconsin Demonstration Project Officer and the Wisconsin State Representative from the Chicago Regional Office.

II. GENERAL CONDITIONS

- A. The State shall have one protocol document that represents and provides a single source for the policy and operating procedures applicable to this Demonstration which have been agreed to by the State and CMS during the course of the Demonstration. During the Demonstration, subsequent changes to the protocol which are the result of major changes in policy or operating procedures should be submitted no later than 90 days prior to the date of implementation of the change(s) for approval by CMS. The STCs and Attachments include requirements which should be included in the protocol. Attachment E is an outline of areas that should be included in the protocol.
- B. The State will submit a phase-out plan of the Demonstration to CMS 6 months prior to initiating normal phase-out activities and, if desired by the State, an extension plan on a timely basis to prevent disenrollment of beneficiaries if the waiver is extended by CMS. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS review and approval.
- C. The CMS may suspend or terminate any project, in whole or in part, at any time before the date of expiration whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs or other legal authority, to challenge CMS's finding that the State materially failed to comply. CMS reserves the right to withdraw waivers at any time if it determines, after good faith consultation with the State, that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable for only normal close-out costs.
- D. The State will comply with:
 - 1. General Financial Requirements (Attachment A)
 - 2. General Program Requirements (Attachment B)
 - 3. General Reporting Requirements (Attachment C)
 - 4. Monitoring Budget Neutrality (Attachment D)
 - 5. Operational Protocol (E)
 - 6. CMS Encounter Data Set Elements (Attachment F)

III. LEGISLATION

- A. All requirements of the Medicaid program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are part, shall apply to the Wisconsin Section 1115 Demonstration. To the extent the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the demonstration in ways not explicitly anticipated in this agreement, CMS shall incorporate such effects into a modified budget limit for the Wisconsin Demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement. CMS will have 2 years after the waiver award date to notify the State that it intends to take action. The growth rates for the budget neutrality baseline, as described in Attachment D, are not subject to this STC. If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the Wisconsin Demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit shall be proportional to the size of the Wisconsin Demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).
- B. The State shall, within the time frame specified in law, come into compliance with any changes in Federal law or regulations affecting the Medicaid program that occur after the waiver award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the waiver, CMS shall incorporate such changes into a modified budget limit for the Wisconsin Demonstration. The modified budget limit will be effective upon implementation of the change in Federal law or regulations, as specified in law or regulations. If the new law cannot be linked specifically with program components that are or are not affected by the Wisconsin Demonstration (e.g., laws affecting sources of Medicaid funding), the State shall submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in Wisconsin, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments shall be made according to the method applied in non-waiver states.
- C. The State may submit to CMS a request for an amendment to the Wisconsin Demonstration to request exemption from changes in law occurring after the waiver award date. The cost to the Federal government of such an amendment must be offset to ensure that total projected expenditures under a modified Wisconsin Demonstration do not exceed projected expenditures in the absence of the Wisconsin Demonstration (assuming full compliance with the change in law).

IV. PROGRAM DESIGN/ OPERATIONAL PLAN

A. Coordination With Other Waivers Or Programs

The State's Title XXI Children's Health Insurance Program, as approved on May 29, 1998 and amended on December 18, 1998 will continue to operate concurrently with the section 1115 demonstration.

B. Enrollment Limits

Applicants with total family income that is no more than 185 percent of the Federal poverty level (FPL) are eligible for BadgerCare. An applicant is an individual who was not receiving Medicaid or BadgerCare in the previous calendar month, or who was not part of a family that was receiving BadgerCare in the previous calendar month. Recipients with total family income that does not exceed 200 percent FPL remain BadgerCare eligible. Recipients are individuals who were receiving Medicaid or BadgerCare in the previous calendar month, or who are part of a family that was receiving Medicaid or BadgerCare in the previous calendar month. "Family" means a child under 19 years of age, the custodial parent of a child under age 19 (if any), and the spouse of a custodial parent (if any) that reside together.

The State retains the option to adjust the BadgerCare applicant income limit when the State enrollment projections exceed budgeted thresholds. As outlined in Attachment C, the State will monitor actual monthly enrollment and will project quarterly enrollment. If quarterly projections show that enrollment will exceed budget thresholds, the State will take the necessary steps to change the income eligibility limits for BadgerCare applicants. To assure full enrollment into BadgerCare, the State shall also have the option of adjusting the income eligibility limit for BadgerCare applicants should it be determined by the State that BadgerCare funding is sufficient, so that the applicant income limit does not exceed 185 percent FPL.

During the demonstration, subsequent changes to the enrollment limit should be submitted as a waiver amendment no later than 90 days prior to the date of implementation of the change(s) for approval by CMS. Within 30 days of receipt of the amendment, CMS will identify, in writing, all significant issues that are to be addressed by the State, and will work with the State toward a final decision within 60 days. The 60-day period does not include the period in which the State is responding to CMS' written comments and questions on the amendment.

The State will include in its amendment the current income eligibility limit, the proposed new income eligibility limit, and the estimated number of eligibles to be enrolled at the new income eligibility limit. In addition, the State must include in its request a description of its efforts to provide outreach and education to BadgerCare applicants and recipients on how this change will/will not impact their participation in the BadgerCare

program, and a description of training for State staff and eligibility and enrollment workers. The State will also include examples of public notice, including a list of papers and/or periodicals in which the notice appears and any other medium in which it is distributed.

The State will not use this process to apply income and resource methodologies that are more restrictive than prior to implementation of the BadgerCare demonstration.

C. Coordination of Services

- a. Linkage Agreements - As part of the protocol, the State must describe how managed care organizations (MCOs) are expected to develop linkage agreements and coordinate care for their beneficiaries with such entities as: public health agencies, school-based health clinics, and family planning clinics. The description shall include the process for exchanging patient specific information while protecting the confidentiality of the patient.
- b. Coordination of Care for Enrollees in Need of Mental Health and Substance Abuse Treatment Services - The State shall ensure that mental health and substance abuse conditions are systematically identified and addressed within the scope of the contract by the beneficiary's primary care provider.
- c. In the protocol, the State shall submit to CMS a plan, developed in consultation with the Indian tribes and/or representatives from the Indian health programs, a plan for patient management and coordination of services for American Indians/Alaskan Natives (AI/AN). (For purposes of this STC, "Indian health programs" are defined as programs operated by the Indian Health Service (IHS); operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the IHS under the authority of the Indian Self-Determination and Education Assistance Act, Pub. L. 93-638; operated by an urban Indian organization pursuant to a grant or contract with the IHS under the authority of title V of the Indian Health Care Improvement Act, Pub. L. 94-437; or operated by tribes or nations that is recognized by the State either by treaty or State law.) The plan shall include: 1) mechanisms and procedures for Indian health programs to receive Medicaid/BadgerCare reimbursement for services provided to AI/ANs beneficiaries receiving care through Indian health clinics; 2) mechanisms and procedures to ensure that Medicaid/BadgerCare coverage and payment of services provided to AI/ANs who are referred by Indian health programs to private providers, or who receive emergency services from private providers; 3) information to be included in the enrollment packet explaining the voluntary enrollment options for AI/ANs; and 4) a monitoring protocol to assess the impact of

Medicaid/BadgerCare on health service delivery to AI/ANs. The State shall submit, on an annual basis, program enrollment data for this population, and shall make these data available to the Indian health programs upon request.

- d. In the protocol, the State shall submit a written plan that describes access to family planning services under BadgerCare. The plan must also delineate how enrollees may self-refer and how the confidentiality of enrollees (particularly adolescents) who receive family planning services will be maintained.

D. Default Assignment

If the approved default assignment algorithm changes, the State must submit the proposed algorithm to CMS for approval prior to its use. Within 30 calendar days of notice of eligibility, if the beneficiary does not choose a health plan, the State shall notify the beneficiaries of their plan assignment, send them member information, and notify them of their right to change plans within ninety (90) days at the time of their enrollment in an MCO and at any time thereafter for cause, and of their right to change primary care providers at least twice without cause, and more than twice for cause. The plan shall take appropriate action to ensure that new enrollees who need special or immediate health care services, as identified by their provider, will receive them in a timely manner. The State will monitor the default assignment rate. If it is determined that the default assignment rates are consistently higher than the rates previously under the section 1915(b) waiver, a corrective action plan will be initiated. As part of the enrollment packet, beneficiaries shall be provided with information concerning their disenrollment rights.

E. Cost Sharing

Families with incomes above 150 percent FPL will pay a monthly premium of 5 percent of family income. The State will monitor disenrollments from the BadgerCare demonstration due to nonpayment of premiums. The State shall send samples of all premium notices and any other public notices relating to imposition of premiums, disenrollment for non-payment of premiums, and beneficiary rights and responsibilities under the premium requirement to CMS for review.

F. Encounter Data Requirements

1. Minimum Data Set - The State shall require (as part of its contract) that all providers submit these data. The State will provide assurances to CMS that person-level data will be submitted to CMS or its designated evaluator within 60 days of its request. (The recommended minimum data set is attached - Attachment F.) The State must perform periodic reviews, including annual validation studies, in order to ensure compliance and shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion. In the protocol, the State shall submit a minimum data set and a description showing how collection of these encounter data is being implemented, monitored, and validated as well as how the State will use the encounter data to monitor implementation of the project, set rates, and feed findings directly into program enhancement on a timely basis.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS

1. The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the BadgerCare Demonstration under section 1115 authority. CMS will provide Federal Financial Participation (FFP) only for allowable, title XIX BadgerCare Demonstration expenditures that do not exceed the pre-defined limits as specified in Attachment D (Monitoring Budget Neutrality for the BadgerCare Demonstration).
2. Wisconsin will be subject to a limit on the amount of Federal title XXI funding that the State may receive on Demonstration expenditures during the waiver period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of Demonstration populations until the next allotment becomes available. Title XIX Federal matching funds will be provided if the title XXI allotment is exhausted.
3.
 - a. In order to track expenditures under this Demonstration, the State will report BadgerCare Demonstration expenditures through the Medicaid Budget and Expenditure System (MBES/CBES), as part of the routine CMS-64 reporting process. Expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9s, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made). The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.c.
 - b. For each Demonstration year, two separate Form CMS-64.9 and/or 64.9p should be submitted reporting expenditures subject to the budget neutrality cap. On the first form, all expenditures (as defined in 3) for adult BadgerCare eligibles under or at 150 percent of the Federal Poverty Level (FPL) shall be reported. On the second form, all expenditures for adult BadgerCare eligibles over 150 percent of the FPL shall be reported (per capita insurance payments to MCOs net of premium contributions by families should be reported on line 18a and the allowed premium contributions, as defined in item 5.d, should be reported on line 29.) The sum of these sheets should represent the expenditures subject to the budget neutrality cap reported in that quarter. When expenditures are being reported from more than one Demonstration year there will probably be multiple pairs of Form CMS 64.9

included for the Demonstration.

- c. The term, “expenditures subject to the budget neutrality cap” includes all Medicaid expenditures on behalf of the adult BadgerCare population under the Demonstration, which includes both expenditures for expansion individuals enrolled in an MCO and expansion individuals eligible but not yet enrolled into an MCO. When the State makes payments to buy into employer-sponsored insurance and the payments are not fully matchable at the enhanced title XXI match rate, the adults share of the payment will be 64.3 percent of the total, which will be reported as an expenditure subject to the budget neutrality cap. This amount will be reported on Form CMS 64.9 line 18.c as described above.
 - d. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are attributable to the demonstration. Procedures regarding the tracking and reporting of administrative costs will be described in the Operational Protocol, to be submitted by the State to CMS under terms specified in Attachment E.
 - e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter two year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.
 - f. The procedures related to this reporting process will be included in the Operational Protocol to be submitted by the State to CMS under Attachment E.
4. a. For the purpose of calculating the budget neutrality expenditure cap described in Attachment D, the State will provide to CMS on a quarterly basis the actual number of eligible member/months (as defined in 3.b.). These will include only member/months (MM) for adult BadgerCare Demonstration eligibles for whose expenditures are matched at the regular FFP match rate (MM should not be reported for adults which are part of title XXI by virtue of the family coverage variance.) This information should be provided to CMS as part of the regular progress report. If a quarter overlaps the end of one Demonstration year (DY) and the beginning of another, member/months pertaining to the first DY will be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the Demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months will be defined in the Operational Protocol.

- b. The term, "eligible member/months" will refer to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months, each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.
- 5. The standard Medicaid funding process for annual grant award states will be used during the demonstration. Wisconsin must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State shall provide updated estimates of expenditures for the waiver population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 annually with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the annual grant award to the State.
- 6. CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment D:
 - a. Administrative costs, including those associated with the administration of the BadgerCare Demonstration, which will not be included in the per eligible per month cost used for the budget neutrality determination;
 - b. Net expenditures of the Medicaid program and prior period adjustments which are paid in accordance with the approved State Plan (including disproportionate share hospital payments); and
 - c. Net medical assistance expenditures made under Section 1115 waiver authority, including those made in conjunction with the BadgerCare Demonstration. Premium collections received from adults will not be used in arriving at net expenditures for this purpose except as specified in item 6 below.
- 7. Premium collection revenues that exceed half of the non-Federal share would offset program expenditures in arriving at net expenditures eligible for FFP under item 5.c. A determination of excess premium collection revenues will be made annually on a demonstration year basis. The share of the premium collection which is allocated to the adult(s) is 64.3 percent of the total.
- 7. The State will certify State/local monies used as matching funds for the BadgerCare Demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by Federal law.

8. Effective 1/1/99, State will be required to submit Medicaid eligibility and claims information to CMS through the Medicaid Statistical Information System (MSIS). Section 2700 of the State Medicaid Manual details the MSIS reporting requirements. The State will follow the reporting requirements outlined in the State Medicaid Manual for expanded eligibility groups included in the demonstration.

ATTACHMENT B

GENERAL PROGRAM REQUIREMENTS

1. To be included as part of the State's contract with an MCO, the State shall require MCOs to protect the confidentiality of all project-related information that identifies individuals. The provisions must specify that such information is confidential and, that it may not be disclosed directly or indirectly except for purposes directly connected with the conduct of the project or the administration of the Medicaid program, including evaluations conducted by the independent evaluator selected by the State and/or CMS, or evaluations performed or arranged by State agencies. Written consent of the individual must be obtained for any other disclosure.
2. The State's MCO contracts and subcontracts for services related to the demonstration must provide that the State agency and the U.S. Department of Health and Human Services may: (1) evaluate through inspection or other means the quality, appropriateness, and timeliness of services performed and (2) inspect and audit any financial records, including reimbursement rates, of such contractor/subcontractors.
3. The State shall submit to CMS for approval, within 90 days from the award of the extension, a draft design of an evaluation design. At a minimum, the report design shall include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the demonstration) that are being tested. The report will discuss the outcome measures that will be used in evaluating the impact of the demonstration during this extension period, particularly among the target population. It will discuss the data sources and sampling methodology for assessing these outcomes. The evaluation design must include a detailed analysis plan that describes how the effects of the demonstration will be isolated from those other initiatives occurring in the State. The report will identify whether the State will implement the evaluation, or select an outside contractor for the evaluation. CMS will provide comments on the report within 30 days of receipt, and the State will submit a final report within 30 days of receipt of CMS comments.

The State will implement the evaluation design, and submit to CMS a draft evaluation report 120 days prior to the expiration of this extension. CMS will provide comments within 60 days of receipt of the report. The State shall submit the final report prior to the expiration date of this extension.

4. CMS may suspend or terminate any project, in whole or in part, at any time before the date of expiration whenever it determines that the awardee has materially failed to comply with the terms of the project. CMS will promptly notify the awardee in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for

Medical Assistance Programs or other legal authority, to challenge CMS's finding that the State materially failed to comply. CMS reserves the right to withdraw waivers at any time if it determines, after good faith consultation with the State, that continuing the waivers would no longer be in the public interest. If a waiver is withdrawn, CMS will be liable for only normal close-out costs.

5. The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the waiver is withdrawn, CMS will be liable for only normal close-out costs.

ATTACHMENT C

GENERAL REPORTING REQUIREMENTS

1. By April 1 of each year, the State will submit Form CMS-416, EPSDT program reports for the previous Federal fiscal year. These reports will follow the format specified in section 2700.4 of the State Medicaid Manual, with data for each line item arrayed by age group and basis of eligibility. All data reported will be supported by documentation consistent with the general requirements of these terms and conditions.
2. CMS and the State will hold monthly calls to discuss progress. The State will submit quarterly progress reports which are due 60 days after the end of each quarter. The reports should include, as appropriate, a discussion of events occurring during the quarter that affect health care delivery, including access to in-plan services and to out-of-plan services; the enrollment process for the new eligible adults, enrollment and outreach activities; default assignments including requests to change primary care providers; quality of care; access; MCO financial performance; complaints and appeals to the State; beneficiary telephone hot line performance; the referral system; the benefit package(s); and other operational and policy issues. The report should include a separate discussion of State efforts related to the collection and verification of encounter data. The report should also include proposals for addressing any problems identified in each report.
3. The State will submit draft annual report documenting accomplishments, project status, quantitative and case study findings, and policy and administrative difficulties no later than 120 days after the end of its operational year. Within 30 days of receipt of comments from CMS, a final annual report will be submitted.
4. At the end of the demonstration, a draft final report should be submitted to CMS for comments. CMS' comments must be taken into consideration by the State for incorporation into the final report. The State should use the CMS Office of Research and Demonstrations' Author's Guidelines: Grants and Contracts Final Reports (copy included with original STCs) in the preparation of the final report. The final report is due no later than 90 days after the termination of the project.
5. The State will submit a phase-out plan of the demonstration to CMS 6 months prior to initiating normal phase-out activities or, if desired by the State, an extension plan on a timely basis to prevent disenrollment of members if the waiver is extended by CMS. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergency circumstances. The phase-out plan is subject to CMS review and approval.

6. The State will also provide CMS with copies of the following enrollment reports:
- Monthly actual enrollment and rolling quarterly projection of BadgerCare HMO and fee-for-service enrollment derived from your Medicaid Management Information System by Medicaid Eligibility Group defined in Attachment A.
 - Monthly report arraying the number of approved applications received by poverty levels of enrollees derived from your Medicaid eligibility system. The applications will be arrayed by bands of percentages of the FPL, such as 151 percent – 160 percent, 161 percent – 170 percent (up to 200 percent).

ATTACHMENT D

**MONITORING BUDGET NEUTRALITY FOR THE
BadgerCare Demonstration**

The following describes the method by which budget neutrality will be assured under the BadgerCare Demonstration. Wisconsin will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. This limit will be determined using a per capita cost method. In this way, Wisconsin will be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles, but not at risk for the number of eligibles. By providing FFP for all eligibles, CMS will not place Wisconsin at risk for changing economic conditions. However, by placing Wisconsin at risk for the per capita costs of Medicaid eligibles, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

For the purpose of calculating the overall expenditure limit for the demonstration, separate budget estimates will be calculated for each year on a demonstration year (DY) basis. The annual estimates will then be added together to obtain an expenditure estimate for both the original 5-year demonstration period ending March 31, 2004, and the 3-year extension period ending March 31, 2007.

Budget neutrality will be determined for each period, the original demonstration period and the extension period as independent periods. The Federal share of this estimate will represent the maximum amount of FFP that the State may receive during each of the periods for the types of Medicaid expenditures described below. For each DY, the Federal share will be calculated using the FMAP rate(s) applicable to that year.

Once all claims and costs are determined and reported through the MBES/CBES system for the first five-year period of the demonstration, Wisconsin must return the Federal share of any budget neutrality deficits incurred over the period. This transaction must be done in accordance with 42 CFR 430.48.

Projecting Service Expenditures

Each demonstration year estimate of Medicaid service expenditures will be calculated as the product of the projected per member/per month (PMPM) cost times the actual number of eligible as reported to CMS by the State under the guidelines set forth in Attachment A section 3.a. As with the offset to with-waiver expenditures, premium collections for adults that are in excess of the allowed amount for non-Federal share will be used to reduce demonstration year budget estimates.

The following are the projected PMPM costs for the calculation of the budget neutrality limit, which are based on trending the State's 1999 calendar year (CY) PMPM cost estimate of

\$121.23 forward at an annual trend rate of 3.48 percent. The first demonstration year (DY 2000) begins July 1, 1999, which reflects applying 6 months of trending to the CY 1999 estimate.

Demonstration years 2003 and 2004 have been adjusted to account for an increase in capitation rates due to a methodology change required by 42 CFR 438.6(c)(3)(iii). Capitation payments in these 2 years are required to be by age/gender rate cells rather than the family rate methodology that was used to construct the original PMPM cost estimate of \$121.23.

The new PMPM targets for Demonstration years 2003 and 2004 were developed by constructing an actuarial equivalent of an “adult only” rate from the base rate of \$121.23. This adult only rate was then trended forward in the same manner as the family rate was to yield a Demonstration year 2003 cost estimate of \$189.47 and a Demonstration year 2004 cost estimate of \$196.06.

In granting an extension to the demonstration, Demonstration years 2005, 2006, and 2007 are trended forward at a rate of 4.2%.

| | |
|-------------------------|-----------------|
| Demonstration Year 2000 | <u>\$123.33</u> |
| Demonstration Year 2001 | <u>\$127.62</u> |
| Demonstration Year 2002 | <u>\$132.06</u> |
| Demonstration Year 2003 | <u>\$189.47</u> |
| Demonstration Year 2004 | <u>\$196.06</u> |
| Demonstration Year 2005 | <u>\$204.30</u> |
| Demonstration Year 2006 | <u>\$212.88</u> |
| Demonstration Year 2007 | <u>\$221.82</u> |

Impermissible DSH, Taxes or Donations

If any health care-related tax which was in effect during the base period, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act, CMS reserves the right to make adjustments to the budget neutrality cap.

Title XXI Expenditures

If title XXI allocations are expended and the State chooses to draw down regular title XIX matching funds for this population under a section 1115 waiver authority, a section 1115 budget neutrality cap and trend rate must be established for this population in consultation with the State. CMS will consider the state’s title XXI expenditure experience in establishing the cap. In order to provide for a seamless continuation of 1115 waiver authority for the expansion population under title XIX, the State should provide CMS with adequate notification if the State's projections indicate that it may exceed its title XXI allocation.

How the limit will be applied

The limit calculated above will apply to actual expenditures for Medical services, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 3-year renewal period, the budget neutrality test will be based on the time period from renewal through the termination date.

Expenditure Review

The CMS shall enforce budget neutrality over the individual periods of the demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, the CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, it shall submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

| <u>Year</u> | <u>Cumulative target definition (period specific)</u> | <u>Percentage</u> |
|-------------|---|-------------------|
| Year 1 | Year 1 budget neutrality cap plus | 8 percent |
| Year 2 | Years 1 and 2 combined budget neutrality cap plus | 3 percent |
| Year 3 | Years 1 through 3 combined budget neutrality cap plus | 1 percent |
| Year 4 | Years 1 through 4 combined budget neutrality cap plus | 0.5 percent |
| Year 5 | Years 1 through 5 combined budget neutrality cap plus | 0 percent |
| Year 6 | Year 6 budget neutrality cap plus | 3 percent |
| Year 7 | Years 6 and 7 combined budget neutrality cap plus | 1 percent |
| Year 8 | Years 6 through 8 combined budget neutrality cap plus | 0 percent |

ATTACHMENT E

OPERATIONAL PROTOCOL

The State will be responsible for developing a detailed protocol describing BadgerCare, including the section 1115 title XIX Demonstration component and the title XXI component. The protocol will serve as a stand alone document that reflects the operating policies and administrative guidelines in the Demonstration. The protocol will be submitted for approval no later than 60 days prior to implementation. CMS will respond within 30 days of receipt of the protocol. The State shall assure and monitor compliance with the protocol. The protocol will encompass all requirements specified within the STCs, including:

1. The organizational and structural administration that will be in place to implement, monitor, and run the Demonstration, and the tasks that each will perform.
2. The organization of managed care networks and the criteria procedures for determining adequate managed care provider capacity by county, as well as the process and criteria applied for provider selection.
3. A complete description of Medicaid services, including family planning services covered under the Demonstration, including those subject to capitation and those otherwise reimbursed.
4. A detailed plan for monitoring the State's coordination of care, utilization, and payment for out-of-plan and wrap-around services.
5. Marketing and outreach strategies including the permissible marketing activities by MCOs.
6. A description of the State's beneficiary education process.
7. A comprehensive description of the enrollment and disenrollment process including the default assignment process.
8. Selection policies and MCO contracting requirements.
9. Capitation (including risk adjustments), incentive plans, and claims payment mechanisms.
10. MCO financial and solvency reporting, and monitoring requirements, including standards for timeliness of claims payment.

11. An overall quality assurance monitoring plan that includes a discussion of all quality indicators to be employed and methodology for measuring such indicators; surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys; the credentialing requirements and monitoring; fraud control provisions and monitoring; and the proposed provider-enrollee ratios, access standards, etc.
12. Submit a minimum data set, and a description showing how collection of plan encounter data is being implemented and monitored; measures that will be in place for ensuring accuracy, validity, and timely submission of data; what resources will be assigned to this effort, and how the State will use the encounter data to monitor implementation of the project and feed findings directly into program change on a timely basis.
13. The complaint, grievance, and appeal policies that will be in place at the State and MCO level.
14. Basic features of the administrative and management data system.
15. Description of all referral authorization plans, and policies and procedures relating to them.
16. Description of how beneficiary access will be guaranteed in case of termination of the MCO contract.
17. A plan for patient management and coordination of services to American Indians/Alaskan Natives under the BadgerCare demonstration.
18. A complete description of the enrollment limit process, including a description of training for State staff and eligibility and enrollment workers, and a description of the public notice process.
19. A complete description of the procedures for financial reporting requirements as specified in Attachment A.
20. A description of the procedures for premium determination, collection, and reporting.

ATTACHMENT F
Recommended Encounter Data Set Elements

| ELEMENTS | TYPE OF RECORD | | | |
|---|------------------------|------|-------|--------|
| | PHYS & OTHER PROVIDERS | HOSP | DRUGS | DENTAL |
| Beneficiary/Enrollee ID | X | X | X | X |
| Beneficiary/Enrollee Name | X | X | X | X |
| Beneficiary/Enrollee DOB | X | X | X | X |
| Plan ID | X | X | X | X |
| Physician/Supplier/Provider ID | X | X | X | X |
| Attending/Ordering/Referring Performing Physician ID | X | X | X | X |
| Provider Location Code/Address | X | X | X | X |
| Place of Service Code | X | X | - | X |
| Specialty Code | X | - | - | - |
| Date(s) of Service | X | X | X | X |
| Units of Service/Quantity | X | X | X | X |
| Principal Diagnosis Code | X | X | - | - |
| Other Diagnosis Code(s) | X | X | - | - |
| Procedure Code | X | X | - | - |
| EPSDT Indicator | X | - | - | X |
| Patient Status Code | - | X | - | - |
| Revenue Code | - | X | - | - |
| National Drug Code | - | - | X | - |
| Dental Quadrant | - | - | - | X |
| Tooth Number | - | - | - | X |